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ABSTRACT

Demographic information indicates that 6% of the general population is hard of hearing or deaf; however, deaf people are significantly underrepresented in drug and alcohol treatment on any given day. Deaf people are a minority whose primary language is American Sign Language (ASL), and information about substance abuse is not easily represented in that language. Communication difficulties encountered by deaf and hard of hearing people, including difficulties in their own families, are discussed. Risk factors of isolation and stress are considered. Besides being isolated by chemical dependency, deaf individuals may be isolated by their language use and not have access to resources that could help them. Often translators are not available for assessment procedures or for treatment, and mainstreaming approaches are unsuccessful without translators. A model program is described using drawing for treatment assignments, with videotaped materials using sign language, voice, and captioning. The program also provides assistive listening devices, TTY access, flashing light signals, and decoders. Follow-up findings and obstacles to recovery and treatment among the deaf are discussed. Factors that increase the probability of success in treatment are listed. (EMK)

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Is There a Substance Abuse Problem Among Deaf and Hard of Hearing Individuals?

Debra S. Guthmann, M.A., Ed. D

Introduction

Demographic information indicate that 6% of the general population is considered to be hard of hearing with one out of every 14 individuals identifying themselves as having difficulty hearing (Schein, 1974). If Deaf people represent one half of one percent of the U.S. population, there should be 4,000 Deaf people in drug or alcohol treatment on any given day (McCrone, 1994). There appears to be no evidence of this occurring.

Communication Obstacles

Communication difficulties often exist in family systems with a Deaf member, since 90% of all parents of Deaf children are hearing (Schein, 1974) and may not be able to communicate with their children. Parents and children belong to different cultures; hearing parents may fear "losing their child to the Deaf community" because they are unable to adequately communicate with their children. As the child becomes older, and visits become less frequent, the communication gaps widen. This lack of communication may put a Deaf child at a higher risk for potential substance abuse problems. As the child grows up, the family may overlook classic symptoms of chemical dependency and attribute them to the fact that the person is Deaf or hard of hearing.

Deaf people are part of a linguistic minority whose primary language is American Sign Language(ASL). When communicating with a Deaf individual, the use of lip reading without the use of American Sign Language is not adequate because of the large number of words that look alike on the lips. In tests, using simple sentences, Deaf people recognize perhaps three or

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four words in every sample that is used. Sit in front of a television set with the sound turned off and see if you can comprehend what is being spoken. The majority of what is being said would not be understood since only 20% of all speech is visible on the lips(Jeffers and Barley, 1971). This is what a Deaf individual is faced with on a daily basis. Lipreading is not a feasible communication option for the majority of Deaf individuals!

ASL is a visually and spatially grounded language that does not provide a direct "translation" of English forms and the concepts represented by English vocabulary and syntax. Thus, knowledge about chemical dependency is not communicated very well in the Deaf community. For example, some key concepts and terms in chemical dependency treatment simply do not exist in the Deaf culture. In treatment settings designed for the mainstream, language and communication are both barriers to participation among Deaf and hard of hearing individuals. Good communication is essential in both the educational-therapeutic and peer interaction dimension of a well-designed program.

People who are Deaf or hard of hearing are referred to as having a hidden disability. The disability does not become evident until the person begins to communicate. It is assumed by the hearing community, that if a person wears a hearing aid, then all listening and hearing problems are solved. Unfortunately, this is not true. Many Deaf and hard of hearing individuals are excluded from normal conversations because others do not realize that they cannot hear even with a hearing aid. Deaf and hard of hearing addicts may be isolated from society because of their chemical use and their deafness. They must overcome not only the effects of deafness but also of a disease which encourages isolation.

Risk Factors

Many Deaf and hard of hearing young people grow up in families and attend schools where their language isolates them from the normal information flow. The availability of information on substance abuse and treatment is fragmentary, haphazard and slow. Essential to prevention, assessment and treatment is having materials and approaches to these chemical dependency topics. For those persons who use ASL or another manual language, it is necessary that these materials and approaches are presented in ways that are readily processed. Currently, the written and visual materials that address this knowledge gap are inadequate and often written at a level the Deaf child cannot understand. Those that are available are not systematically distributed or used.

Deaf adolescents may experience a higher level of stress in their lives than adolescents who can hear. As a result, these adolescents may turn to drinking and drug use to reduce stress and/or fit in with hearing students and peers. Unfortunately, very few studies have been conducted to identify the variables that predict drinking and drug use among deaf adolescents. Dick (1996) found the following school and peer related variables to be predictors of Deaf and hard of hearing adolescents' use of alcohol and marijuana: 1.) School grades were the most salient predictor of marijuana use and respondents with poor grades used marijuana more frequently than those with higher grades; 2.) Deaf and hard of hearing adolescents who attended main-streamed schools and had high numbers of hearing friends at school reported higher rates of alcohol use than those with smaller numbers of hearing friends at school.

Assessment Considerations

When Deaf or hard of hearing individuals are in need of a chemical dependency

assessment, often they are interviewed by a hearing person who is not fluent in American Sign Language. There have been incidents where an assessor attempts to complete the interview process by writing back and forth to the Deaf person or expecting him/her to read lips. Both of these approaches are unreliable as well as being culturally and ethically inappropriate! This is due in part to the fact that Deaf or hard of hearing individuals being assessed may not be familiar with the language used by the assessor. If the assessor is not fluent in ASL, an interpreter needs to be used to effectively convey communication during the interview process. The addition of a third party will most likely change the dynamics of the assessment and possibly the validity of the interview session if the interpreter is not fully qualified. There are few interpreter training programs in the United States that focus on the specialized substance abuse vocabulary necessary when assessing Deaf and hard of hearing individuals. It is imperative that any assessor utilizing an interpreter makes sure to use a fully certified and qualified interpreter.

Treatment Considerations

Suppose that you are a person who speaks and writes only in the English Language and you are in need of chemical dependency treatment. The only program available to you is one where all staff speak and write in a foreign language. It would be extremely difficult to get the information needed from the treatment program and most likely, the experience would be negative for you. Unfortunately, many Deaf and hard of hearing individuals are faced with this dilemma when they enter a hearing treatment program where communication is not accessible to them.

The substance abuse treatment field has recognized the importance of addressing drug and alcohol dependency with approaches that are sensitive to client's cultural needs that respect

and utilize the primary language of the client population. The substance abuse profession is beginning to identify the Deaf and hard of hearing community as a community in need of specialized treatment approaches.

Often a Deaf or hard of hearing person is admitted to a treatment program designed to serve hearing people and is provided access to that program via the services of sign language interpreters. When Deaf clients are main-streamed with a group of hearing patients, they may not be able to express themselves articulately enough to communicate clearly with different individuals and the group. If a sign language interpreter is not available, the leader of the group may try to communicate with the person through pencil and paper, trying to explain some of the issues. Without the presence of the interpreter, the deaf individual misses out on all the information shared during the therapeutic group and may get feedback from their facilitator that they were not paying attention or that they only hear what they want to hear. Most of the time an interpreter is not provided 24 hours a day but is only made available to the client on a very limited basis. The absence of an interpreter precludes Deaf and hard of hearing individuals equal access to staff as well as severely restricting their interactions with other clients (i.e. meal times, free time, etc.) Such interactions are a key part of the treatment process. The optimal placement for Deaf and hard of hearing individuals is with staff who are fluent in ASL and sensitive to Deaf culture.

The most therapeutic process of treatment is not necessarily the groups and lectures, but rather the interaction and fellowship that occurs among peers in their free time. Deaf and hard of hearing clients often feel that they miss out on this interaction and fellowship. When Deaf clients must depend solely on the support of interpreters, the sense of bonding is vague and the

emotional impact is usually lost because interaction is through a third person. Sometimes an interpreter is unfamiliar with chemical dependency treatment and recovery language. The stage of recovery can be highly emotional, stressful and very intense. When misinterpretations occur, it becomes frustrating for all involved and can even on occasion be harmful to the client. Interpreter training programs need to add vocabulary related to chemical dependency to their already existing curricula.

A Model Program

There are very few national inpatient treatment programs that are designed specifically to work with Deaf and hard of hearing individuals. One of these programs is the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals(MCDPDHHI). This program utilizes a 12-step philosophy and uses treatment approaches that are provided by a staff fluent in ASL and knowledgeable about Deaf culture. The MCDPDHHI currently receives federal funding from the Department of Education to provide training in the area of substance abuse and Deafness to professionals on a national basis. From 1990-95, this Program received federal funding from the Center for Substance Abuse Treatment to be a model program. Instead of utilizing primarily reading and writing in treatment, language barriers are removed by focusing on the use of drawing for treatment assignments. All written materials have been modified to meet the individual needs of the client and video taped materials are presented using sign language, voice and captioning. The Program also provides complete access to all clients by utilizing assistive listening devices, TTY's(telecommunication devices for the Deaf), flashing light signals and decoders.

Guthmann (1996) studied the treatment outcomes of 100 individuals who completed

treatment at the MCDPDHHI. The clients were followed for one year following treatment to determine which variables had the greatest impact upon treatment outcomes. The study found that the variables having the greatest impact on the ability to maintain sobriety after treatment completion were attendance at Twelve Step meetings, the ability to talk to family about sobriety and being employed. Of Deaf and hard of hearing clients entering the MCDPDHHI, 75% were unemployed and the research indicated that there was a strong relationship between abstinence and employment. There is a need to make vocational rehabilitation a strong component of inpatient treatment and the aftercare that follows. In the study that was completed in 1996, Guthmann found similarities in the characteristics of what contributes to overall success in recovery for Deaf, hard of hearing and hearing individuals. This indicates that if the chemical dependency treatment provided to a Deaf and hard of hearing individual is accessible, the variables that are necessary to maintain sobriety are similar in the hearing and Deaf populations.

Obstacles to Treatment and Recovery

The Deaf and hard of hearing community is a small, closeknit group who tend to view substance abuse very negatively. If you have a 'bad habit' you are perceived as a 'bad person' who puts the well-being and public image of the group in jeopardy. This shame interacting with the cultural, linguistic and educational isolation of Deaf and hard of hearing people, leads to reluctance to acknowledge drug and alcohol abuse. There is a negative stigma associated with those individuals in the Deaf community who are addicts.

Another problem encountered is the "deaf grapevine" within the Deaf and hard of hearing community. The idea of confidentiality is less cherished among Deaf and hard of hearing individuals than it is among the hearing. The relationship of confidentiality and its importance

to recovery is almost as difficult to comprehend and accept as the concept that addiction is a disease which is treatable. Thus, the grapevine serves to reinforce the addicted individual's need to keep his or her problem a secret.

When a Deaf or hard of hearing person completes treatment, there are few recovering individuals fluent in ASL or Deaf and hard of hearing that are capable of being sponsors. When thinking of reaching out for help, confidentiality is a fear and a concern. This lack of a sense of community makes Deaf and hard of hearing people feel even more isolated. If confidentiality cannot be respected within a small closeknit community it makes Deaf and hard of hearing people more apprehensive of the outside world.

The major problem faced by Deaf and hard of hearing substance abusers as well as by Deaf and hard of hearing people in general is communication. AA's basic slogan, "Call before you pick up your first drink," poses a real problem for Deaf and hard of hearing addicts. Only a limited number of treatment programs have accessible telephones(telecommunication devices/ TTY's) and few treatment centers own this equipment. Moreover, this may threaten the confidentiality and the integrity of the therapeutic relationship. Interpreters are often mistrusted either because of preconceptions, because they are hearing or because the interpreter is known to the client.

A common suggestion in recovery is to avoid old acquaintances (people, places and things) that provided reinforcers for the substance abuse. Their circle of Deaf and hard of hearing friends is limited; therefore, they will have a tendency to associate with previous friends who may still be using chemicals or be placed in the same stressful situations again, putting the client at risk of returning to a life of chemical dependency. Many Deaf and hard of hearing

people, attempting recovery, will relapse because of loneliness.

There is also a lack of options in recovery related programs, services and opportunities for Deaf and hard of hearing people. Only a few chemical dependency related services, programs and self-help groups are available that are accessible through interpreters. This compares to countless numbers of services and programs that are freely accessible to all those who are hearing and non-disabled. The Americans with Disabilities Act(ADA) which was passed by the legislature a few years ago, was important because it prohibits discrimination in state, local and private sector services whether or not these programs get federal funding. Title III of the ADA prohibits discrimination against people with disabilities in privately owned public accommodations such as private drug and alcohol treatment facilities. Obviously, despite this act, discrimination occurs every day to Deaf and hard of hearing people since needed services are primarily offered in settings that are not fully accessible.

Conclusion

In order for Deaf and hard of hearing individuals to have a reasonable chance of being successful in a recovery program, a number of things must first occur: 1.) there is a need for accessible Twelve Step groups; 2.) education/prevention services should be provided to Deaf and hard of hearing persons of all ages; 3.) there is a need for accessible outpatient, inpatient and aftercare services; 4.) training opportunities about specialized treatment considerations should be offered to professionals working in the field of chemical dependency; 5.) more interpreter training programs are needed that offer specialized training in the area of chemical dependency; 6.) there is a need for more chemical dependency counselors who are fluent in American Sign Language; 7.) additional research is needed in the area of chemical dependency

and the prevalence within the Deaf and hard of hearing community; 8.) and there is a need for vocational rehabilitation counselors to work closely with chemical dependency treatment programs.

For person's who are Deaf or hard of hearing, the principles of addiction are the same as they are for hearing people, yet these individuals are currently unable to fully access the resources available to hearing individuals. Deaf and hard of hearing individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for chemical dependency, since treatment efforts are typically not grounded in culturally specific knowledge. Ideally, individuals who successfully complete a alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible Twelve Step meetings. This kind of environment is unavailable for the majority of Deaf and hard of hearing individuals. Because Deaf and hard of hearing people make up a low incidence population, professionals and the recovering community need to work together on a state, regional and national basis to make sure that accessible services are being provided for Deaf and hard of hearing individuals.

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References

Dick, J. (1996). Signing for a high: a study of alcohol and drug use by deaf and hard of hearing adolescents. Rutgers University, New Brunswick, New Jersey. Dissertation Abstracts International, 57(6A), p. 2675.

Guthmann, D. (1996). An Analysis of Variables that Impact Treatment Outcomes of Chemically Dependent Deaf and Hard of Hearing Individuals. University of Minnesota, Minneapolis, Minnesota. Dissertations Abstracts International, 56(7A), pp. 2638.

Jeffers, J. & Barley, M. (1971). Speechreading (lipreading), Springfield, Illinois: Charles C. Thomas.

McCrone, W. (1994). A two Year Report Card on Title I of the American Disabilities Act: Implications for Rehabilitation Counseling with Deaf People. Journal of American Deafness and Rehabilitation Association, 28(2), 1-20.

Schein, J. (1974). The Deaf Population of the United States. National Association of the Deaf, Silver Springs, Maryland.